

Community Health Needs Assessment Reference Toolkit

Arkansas Assessment Initiative
Hometown Health Improvement
February 29, 2012



Arkansas Department of Health
Keeping Your Hometown Healthy



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Description: The Arkansas Assessment Initiative will strive to improve the processes and outcomes of community health assessments to enable us to complete community health assessments that yield the most comprehensive, valid, and reliable picture of the health in all of our communities.

The **Arkansas Assessment Initiative**, funded by a Center for Disease Control (CDC) grant, is a cooperative effort that joins people and organizations in the search of the best possible information concerning community health assessments. Assessment is a core function of public health and refers to the systematic collection, assembly, analysis, and dissemination of information about the health of a community.

ADH's Hometown Health Initiative (HHI) has accomplished the important task over the past ten years of collecting and sharing information about the health of our communities on the local county level. Although a large variety of current national and state data is easily obtained through web channels, this information may not be appropriate for multiple county level uses and more specific information may be required to meet that community's specific needs.

HHI combines the traditionally gathered census demographic information and information gathered through the Behavioral Risk Factor Surveillance Survey (BRFSS) and the Youth Risk Factor Survey (YRBS) to produce a useful data set for each county. These county level surveys are based on English language proficiency and traditional (land-line) telephone access. This creates a challenge as throughout Arkansas (and nationally) cell phone usage has increased, while fewer people have land lines at home. Additionally the survey is typically completed in English, which may exclude information from our many migrant and immigrant residents that may not speak English. Beginning this year the survey research center did have Spanish language interviewers available.

A basic or baseline understanding of the community's health is vitally important before any new policies or interventions are implemented. Without accurate information on the health status of a community and a clear understanding of the available resources, we cannot make informed decisions about which areas should have priority, which policies might be effective, or which interventions might be possible to implement. Cost and effectiveness must be evaluated to determine how and which programs are supported and continued.

To assist in improving our understanding of health status and disease burden in all components of our diverse population, community health assessments must be adapted to address the culture and language of each community being surveyed. Arkansas' unique challenges lie in our poor rural areas and with the growing Hispanic and Marshallese populations. The Arkansas Assessment Initiative will strive to improve the processes and outcomes of community health assessments to enable us to complete community health assessments that yield the most comprehensive, valid, and reliable picture of the health in all of our communities. This five year CDC grant funding not only enables ADH and HHI to create the Arkansas Assessment Initiative, but also to provide the mechanism with which to share the information gained concerning improved community health assessments processes with other states and organizations so that they may be assisted in successfully meeting this challenging aspect of Public Health.

Executive Summary

Health is a resource; necessary for physical growth and reproduction, educational endeavors, personal relationships and professional development. Health status is influenced through social determinants, access to services, environmental exposures, trauma, genetic traits, and complications of chronic disease. While many health issues can be effectively addressed through prevention and upstream interventions; balanced nutrition, exercise, rest and stress reduction support healthy living on both an individual and community level.

A community health assessment is a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community. An ideal assessment includes input from key leaders and affected members of a community, information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, social determinants of health, health inequity, and information on how well the public health system provides essential services. Community health assessment data inform decision-making, the prioritization of health concerns, and support the development, implementation, and evaluation of community health improvement plans. Much of the information contained within this guide are internet resources which were accessed between 10/1/11 and 2/23/12. Efforts to correctly cite all included materials were taken and the compilers ask forgiveness for any missed references.

This guide utilizes freely available county level data augmented when necessary. It is essentially important to take care with interpreting data sources or collecting data. Measurement scales vary among providers and populations may or may not be age adjusted. National data sources typically rely on local input; then perform a number of rigorous tests and report back with a consistent format. State sources collect and process data, submit to a national depository and when authorized; report locally. There may be long time lag in data collection and reporting. The data report may be in a format not useful for your needs. Problems in data collection methodology are inherent. Models differ in the weighting of types and data averages. Local unmeasured influences like environmental quality may have a significant effect on the community, but have no consistent or reliable measurement methodology available. Community health needs assessment leads to a better understanding of the community; the resources at hand and the unmet needs.

Diagnostic procedures are a large portion of health care costs, but we cannot safely operate without them. No reputable dentist would drill a decayed tooth without an x-ray; no OB will deliver without a sonogram and vital signs are always recorded for ED patients. While we cannot actually count the pulse or respirations of a community, we can still accurately measure vital signs. Community vital signs are known as Community Health Status Indicators. Links to Community Health Data resources are posted at <http://www.healthy.arkansas.gov/programsServices/healthStatistics/Pages/CountyDataList.aspx> . This CHNA reference toolkit will guide you through a simple procedure to use these data sources to complete the process to produce a Community Health Needs Assessment report document, a power point presentation and a community directory.

VISION, GOALS and OBJECTIVES:

VISION- *All Arkansas' live long, healthy lives.*

GOAL- Provide a sustainable consistent format utilizing Arkansas specific data sources to complete a Community Health Needs Assessment to fulfill the standards of Public Health Accreditation; support the requirements for NFP designated Hospitals; and to promote community health improvement.

OBJECTIVES:

- 1) To facilitate the community health action cycle via the assessment process through provision of a simple and cost effective format to obtain local data, complete appropriate reports and gain community support in a time sensitive manner.
- 2) Strengthen existing Health Care Provider and Community relationships through participation in a local Hometown Health improvement coalition.
- 3) To assist communities to develop, implement and monitor a community health improvement plan using Healthy People 2020 goals and objectives that are based on community priorities
- 4) Create and distribute a community resource directory that will be regularly updated (preferably annually but at least every 3 years)
- 5) Advocate for educational experiences in the community i.e. support and participate in classroom, field, clinical and nontraditional instructional settings
 - a) Health Education opportunities for community members- (ex. tobacco cessation, obesity prevention, DSME , HPTN reduction, etc)
 - b) Health and allied care provider training and practice sites- (ex. resident, intern, nursing, EMT, ER & patient care tech, RT, PT & OT, Allied HCP, etc)
 - c) Community Health Care Worker- (ex. promote's curriculum and community advocacy activities)
- 6) To protect and promote Arkansas hospitals, public health system and communities.

ABSTRACT

USING BRFSS IN ARKANSAS TO PROVIDE A SUSTAINABLE DATA RESOURCE TO CONDUCT COMMUNITY HEALTH NEEDS ASSESSMENT ON THE STATE AND LOCAL LEVEL.

Emily L. Harris MPH, Cheryl J. LeDoux MPH

Introduction: Assessment is a core function of public health and promotes planning for community health improvement through identification of emerging health problems and the tracking of health objectives. The Arkansas Assessment Initiative (AR-AI) funded by a CDC grant, is a cooperative effort that joins people and organizations in the search of the best possible information concerning community health needs assessments. Eighty six community coalitions across Arkansas work together to identify and address community health concerns.

Objective: AR-AI is facilitating the community health improvement action cycle via the assessment process through creation and provision of a simple and cost effective Community Health Needs Assessment (CHNA) reference toolkit. The toolkit relies on a concise methodology with clear easy to follow step by step guidance to obtain local data, complete appropriate reports and gain community support in a time sensitive manner.

Method: Common health indicators are estimated each year for each county in Arkansas and made available on the ADH website. Arkansas BRFSS (Behavioral Risk Factor Surveillance System) maps graphically display the prevalence of selected health indicators at the county level and are a key component in the CHNA guidance.

Result: A sustainable consistent format to complete a CHNA facilitates Arkansas rural hospitals efforts to meet Affordable Care Act requirements to maintain their NFP tax status and supports Arkansas Department of Health work towards National Public Health Accreditation.

Conclusion: Development of a consistent and sustainable tool that can be used in a cyclical nature to assess and evaluate ongoing health care status in Arkansas.

COMMUNITY HEALTH NEEDS ASSESSMENT

TIMELINE FOR COMPLETION: *This can be accomplished in 90 days.*

Basic steps - Mobilize, Assess, Plan, Implement, Track

Mobilize: Identify key leadership roles, steering and general community coalition membership

Assess: Gather and prioritize data specific to service area, inventory resources, identify responsible parties in the community

Plan: Customize HP2020 objectives to S.M.A.R.T objective format to support Community Health Improvement Action Cycle

Implement: Finalize work plan and communicate to facilitate success

Track: Apply evaluation framework, maintain data quality, validity, and reliability

Deliverable Products at Process Completion

Community Health Assessment Data Presentation

Community Resource Inventory Directory

Community Health Needs Prioritized List (Data driven with Local Expertise)

Customized S.M.A.R.T HP2020 objectives to support CHIP action cycle

Community accepted recommendations for best practices with party responsible for implementation identified

Planning for current and future tracking through evaluation methods and recurrent assessment on a three year cycle

Final report capable of fulfilling requirements for PHAB and IRS; to be released both electronically and in a printed format via an organized public relations event.

Time Line/ Basic Steps to Complete CHNA

DAY 0	DATE TO BE COMPLETED:	STAGE:	TASK:	RESPONSIBLE Party For Completion:
1		MOBILIZE /PLAN	Identify the CHNA Leader	Consensus
10		MOBILIZE	Connect with local HHI coalition / Invite Community leaders to participate	CHNA leader
15		MOBILIZE	Create Steering Group from 1-5 interested parties/ community leaders. Schedule four (4) Steering Group meetings (face-to-face, or conference call)	CHNA leader
15		MOBILIZE /PLAN	<p>Steering Group Meeting #1- Determine –</p> <p><u>A. Timeline Completion dates</u></p> <ul style="list-style-type: none"> ▪ Coalition meetings #1 & 2 ▪ Collaborate with HHI ▪ Press conference/official release date. <p><u>B. Service area boundaries</u></p> <p><u>C. Steering Group Member Roles /Responsibilities –</u></p> <ul style="list-style-type: none"> ▪ 1. Secure partnership agreement /General community coalition membership/ ▪ 2. Data Presentation/Final Report Creation ▪ 3. Resource Directory Update/Creation- ▪ 4. Public Information sharing – 	Steering group responsibility/ Consensus
20		ASSESS	<p>Steering Group Meeting #2-</p> <ul style="list-style-type: none"> ▪ Review /approve progress in 4 main areas of responsibility above ▪ Prepare for Gen. Comm. Coalition Meeting #1- secure meeting place, invite attendees, prepare 	Steering group responsibility

			MOU and data presentation, print resource templates,	
30		PLAN	Prepare data presentation and ADH county data profiles, SMART objectives	CHNA leader
30		PLAN/IMPLEMENT	Coalition Meeting #1- Present data and facilitate discussion to identify priorities – share resource inventory template and gather responses. Finalize timeline. SMART objectives	CHNA leader/ Consensus
40		ASSESS/PLAN/IMPLEMENT	Steering Group Meeting #3- <ul style="list-style-type: none"> ▪ Review /approve progress in 5 areas above ▪ Prepare for Coalition Meeting #2-secure meeting place, invite attendees, print resource directory, inventory appropriate best practice recommendations 	Consensus CHNA leader /
60		IMPLEMENT	Coalition Meeting #2- <ul style="list-style-type: none"> ▪ Review appropriate Best Practice recommendation & responsible parties with SMART objectives ▪ Share completed resource directory 	CHNA leader/ Consensus
80		IMPLEMENT	Prepare final report/ plan for next three (3) year cycle	CHNA leader
80		TRACK	Steering Group Meeting #4- <ul style="list-style-type: none"> ▪ Review final report/documents ▪ plan for next three (3) year cycle 	Consensus
90		TRACK	Distribute final CHNA report/ resource directory <ul style="list-style-type: none"> ▪ electronically and printed 	CHNA leader

What is a Community Health Needs Assessment?

A community health assessment is a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community.

An ideal assessment includes information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services.

Community health assessment data inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans.

- What health conditions exist in our community?
- Why do health conditions exist?
- What assets do we have?
- What system strengths can we leverage?
- What system weaknesses have to be improved?
- What forces affect how we respond?
- What policy choices or critical challenges must we address in order for us to fully achieve our vision?

Common Elements in CHNA Models

- 1) Develop an assessment plan
- 2) Engage the community
- 3) Define the population
- 4) Identify community health indicators that align with your community's vision or goals
- 5) Collect data
- 6) Analyze data
- 7) Identify health priorities
- 8) Report results

HP 2020 Framework for Implementation

MAP-IT: Mobilize, Assess, Plan, Implement, Track.

This framework can be used to plan and evaluate public health interventions to achieve Healthy People 2020 objectives.

Working Collaboratively with System Partners

- 1) Ask your partners what their individual interests are? What do they need to get out of an assessment process? What requirements are they seeking to meet?
- 2) Identify common ground. Articulate a shared vision or goal.
- 3) Design a process that is focused on the shared vision or goal while accommodating at least some individual interests.
- 4) Identify set of indicators that align with common vision or goal and that can meet at least some individual interests.
- 5) Identify existing data available among all partners to avoid unnecessary data collection.
- 6) Divide and conquer. Assign roles and responsibilities based on organizational assets and strengths. Avoid duplication of effort.

Structuring Partnerships and Coalitions

- 1) One lead organization
- 2) One facilitating organization
- 3) Partnership led process
- 4) Organize by steps in the process
- 5) Hire consultant who consults with partnership, lead organization, or facilitating organization

Collaborative Benefits

- Economies of scale
- Improve system efficiencies
- Reduce redundancies
- One comprehensive assessment can meet several types of requirements
- No one entity can fully address issues identified by assessments
- Funders award effective partnerships
- Collective action results in more collective gain

Effective Communication

- Plan ahead
- Think carefully about roles and responsibilities
- Craft tailored messages, articulate a win-win
- Leverage people with established relationships to engage partners
- Use their language

HP 2020: Framework for Implementation

No two public health interventions are exactly alike. But most interventions share a similar path to success: **Mobilize, Assess, Plan, Implement, Track.**

Otherwise known as MAP-IT, this framework can be used to plan and evaluate public health interventions to achieve Healthy People 2020 objectives. Whether you are a seasoned public health professional or new to the field, the MAP-IT framework will help you create your own path to a healthy community and a healthier Nation.

Use these tools and resources as a reference. Each of the 5 MAP-IT sections includes questions to ask and answer, a brief overview, Healthy People 2020 tools, and links to related resources.

Choose one of the steps below to get started:

Mobilize Assess Plan Implement Track (MAP-IT)

Mobilize

Questions To Ask and Answer:

What is the vision and mission of the coalition?

Why do I want to bring people together?

Who should be represented?

Who are the potential partners (organizations and businesses) in my community?

Assess

Questions To Ask and Answer:

Who is affected and how?

What resources do we have?

What resources do we need?

Plan

Questions To Ask and Answer:

What is our goal?

What do we need to do to reach our goal? Who will do it?

How will we know when we have reached our goal?

Implement

Questions To Ask and Answer:

Are we following our plan?

What can we do better?

Track

Questions To Ask and Answer:

Are we evaluating our work?

Did we follow the plan?

What did we change?

Did we reach our goal?

Planning Resources

Use these resources from the Federal government to help plan your public health intervention. You will find additional links to specific planning and tools and resources throughout the MAP-IT sections.

[Centers for Disease Control and Prevention's \(CDC\) Health Impact Assessment](#)

[CDC's Healthy Communities Program](#)

[Healthy People 2020 program planning tools \[PDF - 551 KB\]](#)

U.S. Department of Health and Human Services (HHS)

[View the organizational chart of HHS offices and agencies](#)

[View the complete list of HHS offices and agencies](#)

State Healthy People Plans

[See a selection of State plans based on Healthy People 2010](#)

Funding Resources

Using Healthy People To Make the Case for Funding

1. **Get the data.** Use Healthy People as a data source to support applications for grants or other funding opportunities.
2. **See how you measure up.** Compare your city or State to national baseline data in Healthy People.
3. **Connect to something larger.** Tie your local health promotion efforts to a national public health movement.
4. **Identify new stakeholders and partners.** Make connections across Healthy People topic areas or with professionals working in other States.
5. **Plan a strong public health program.** Healthy People provides a framework for planning, goal setting, and agenda building

Links to Examples of Community Health Needs Assessments ToolKits

National Association of City and County Health Officials (NACCHO)
www.naccho.org/topics/infrastructure/mapp/framework/mapp

Comparison of the ACA Hospital Requirements and Accreditation Requirements and North Carolina assessment Process
<http://www.healthycarolinians.org/library/pdf/CHA>

North Carolina Department of Health and Human Services
www.hsl.unc.edu/services/guides/communityHealth.cfm
www.healthycarolinians.org

ACHI Toolkit
www.assesstoolkit.org

New York State
www.health.ny.us/statistics/chac/10_steps.htm

UNC Health Sciences Library
<http://guides.lib.unc.edu>

World Health Organization - Recommended Practices for Enhancing Community Health Improvement
[Http://communityhealth.ku.edu](http://communityhealth.ku.edu)

Floridashealth.com
www.doh.state.fl.us/planning_eval/CHAI/Resources/Field

Washington State
<http://assessnow.info/resources>

Common Sources of CHNA Data

1) Local, state, national databases

- County Health Rankings
- State vital records

2) Previously conducted health assessments or reports

- United Way CHA
- Hospital CHNA
- Community Health Centers

3) Partners who have access to data through their organizations

- County government agencies such as courts, police, schools, libraries, parks, city planners
- Non-profit organizations
- Managed care organizations
- Universities and colleges
- Chamber of Commerce

PUBLIC HEALTH INFRASTRUCTURE

HP 2020 describes Public Health Infrastructure as “the foundation for planning, delivering, and evaluating public health ... provides the capacity to prepare for and respond to both acute (emergency) and chronic (ongoing) threats to the Nation’s health. Three key components enable a public health organization to deliver public health services. These components are:

- A capable and qualified workforce,
- Up-to-date data and information systems,
- Public health agencies capable of assessing and responding to public health needs

HP 2020 identifies 17 objectives to assess public health infrastructure. PHI-15 addresses health improvement plans and PHI-17 addresses public health accreditation.

PHI-15 Increase the proportion of Tribal, State, and local public health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have implemented a health improvement plan linked with their State plan

PHI-17 (Developmental) Increase the proportion of Tribal, State, and local public health agencies that are accredited.

The Public Health Accreditation Board (PHAB) is the national organization that accredits Tribal, state, local and territorial public health departments. The PHAB Standards overview is included. (See Appendix for PHAB Standards and Measures 1.0) The goal of national public health department accreditation is to improve and protect the public’s health by advancing the quality and performance of public health departments.

The NPHPSP is a National Partnership initiative that has developed National Public Health Performance Standards (NPHPSP) for state and local public health systems and for public health governing bodies. (<http://www.cdc.gov/nphpsp/index.html>)

The 10 Essential Public Health Services provide the fundamental framework for the NPHPSP instruments, by describing the public health activities that should be undertaken in all communities.

10 Essential Public Health Services

<http://www.cdc.gov/nphpsp/essentialServices.html>

The **Essential Public Health Services** provide the fundamental framework for the NPHPSP instruments, by describing the public health activities that should be undertaken in all communities.

The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. This steering committee included representatives from US Public Health Service agencies and other major public health organizations.

The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Additional Resources

[Essential Public Health Services Presentation](#)  [PDF - 642KB] [PowerPoint](#)  [PPT - 1.15MB]

[Crosswalk of Model Standards and Key Points within the Three NPHPSP Instruments](#)  [PDF - 135KB]

Public Health Action Cycle- ASSESSMENT



The Public Health Action Cycle consists of three main components: Assessment, Policy Development, and Assurance. Each of these activities builds upon the others in a continuous and interactive manner.

Assessment is a primary component in sustaining Community Health. The cycle of assessment includes a thorough review of available data, exchange of information between community members, creation of a resource directory, identifying measurable objectives and striving to reach the goal of improved health for all.

Policy Development and Implementation requires planning and resources. Action items to fulfill the terms of measurable objectives are completed by parties willing to be responsible for completion. Data driven decision making conserves scarce resources and encourages shared ownership in the responses to the identified community health improvement challenges.

Assurance will ease evaluation through the use of measurable objectives created in the assessment phase. Outcome and process evaluation aspects provide insight into where experience and knowledge can highlight the way to community health improvement. Healthy People 2020 provides the opportunity to establish a baseline, apply an appropriate improvement factor (ex. 10% over 10 years) and evaluate progress towards reaching the objectives.

The Action Cycle may be the most satisfying and challenging phase of the MAPIT process. During this phase, the efforts begin to produce results. Community coalitions in collaboration with the local public and private health care system, with other key community leaders develop and implement a community health improvement action plan for addressing the identified strategic issues. Sustaining the process over time is fundamentally important

The Action Cycle can be simply summarized as follows:

- **Assessment/Planning** -- Determining what and how will be done, and who will do it
- **Implementation** -- Carrying out the activities identified in the planning stage.
- **Evaluation** -- Determining what has been accomplished.

ACA/ IRS Requirements for NFP Hospitals.

The Affordable Care Act requires not for profit hospital organizations to conduct Community Health Needs Assessment: Charitable and Non Profit Hospitals ---Schedule H (Form 990) (See appendix)

IRS has created a page on IRS.gov for information about Form 990 and its instructions, at www.irs.gov/form990 . Information about any future developments affecting Form 990 (such as legislation enacted after publication of Schedule H) will be posted on that page.

The Patient Protection and Affordable Care Act (Affordable Care Act),

enacted March 23, 2010, Pub. L. No. 111-148, added section 501(r) to the Internal Revenue Code. Section 501(r) includes additional requirements a hospital organization must meet to qualify for tax exemption under section 501(c)(3) in tax years beginning after March 23, 2010. These additional requirements address a hospital organizations financial assistance policy, policy relating to emergency medical care, billing and collections, and charges for medical care. Also for tax years beginning after March 23, 2012, the Affordable Care Act requires hospital organizations to conduct community health needs assessment.

The Community Health Needs Assessment requirements of section 501(r)(3) are effective for tax years beginning after March 23, 2012. Accordingly, the questions in Part V, Section B, about community health needs assessments (lines 1 through 7) are optional for any tax year beginning before March 24, 2012.

Hospital organizations required to file Form 990 and Schedule H must complete all parts and sections of Schedule H for the 2011 tax year except for lines one through seven of Part V, Section B which relate to community health needs assessments. These lines will remain optional for tax year 2011 and are required only for tax years beginning after March 23, 2012.

IRS has provided as a courtesy a draft of tax form 990 and instructions.

<http://www.irs.gov/pub/irs-dft/i990sh--dft.pdf> Do not file draft forms. Also, do not rely on draft instructions and publications for filing. Drafts of instructions and publications are usually subject to at least some changes before being officially released. All early releases of draft forms, instructions, and publications are available at www.IRS.gov/draftforms.

About Healthy People

Healthy People provide science-based, 10-year national objectives for improving the health of all Americans. For 3 decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Introducing Healthy People 2020

Healthy People 2020 continues in this tradition with the launch on December 2, 2010 of its ambitious, yet achievable, 10-year agenda for improving the Nation's health. Healthy People 2020 is the result of a multiyear process that reflects input from a diverse group of individuals and organizations.



Vision

A society in which all people live long, healthy lives.

Mission

Healthy People 2020 strives to:

Identify nationwide health improvement priorities.

Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress.

Provide measurable objectives and goals that are applicable at the national, State, and local levels.

Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge.

Identify critical research, evaluation, and data collection needs.

Healthy People Overarching Goals

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

Four Foundation Health Indicators

- General Health Status
- Health-Related Quality of Life and Well-Being
- Determinants of Health
- Disparities

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